MEETING REPORT

Public-Private Partnerships for Improving Access to Pharmaceuticals: Lesson from Field Implementation in Selected Countries

Initiative on
Public-Private
Partnerships
for Health

ALLEVIATING THE HEALTH CONSEQUENCES OF POVERTY
BY ENHANCING PUBLIC-PRIVATE COLLABORATION

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Report of a Meeting Sponsored by the Inititiave on Public-Private Partnerships for Health (IPPPH)

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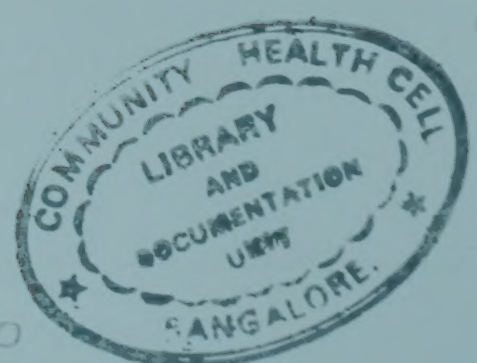

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Executive Summary

This report is based on a meeting on public-private partnerships (PPPs) for improving access to pharmaceuticals, organized by the Initiative on Public-Private Partnerships for Health (IPPPH). The meeting was held on the 10-11 November 2002 at Forum 6, the annual meeting of the Global Forum for Health Research, in Arusha, Tanzania (see Annex 1: Agenda). It brought together funders, implementers and participants of PPPs engaged in improving access to existing drugs to combat 'neglected' diseases and other health problems in low- and middle-income countries (LMICs). The aim was to enable them to share their experiences and to highlight practices that can maximize the benefits of a PPP approach and minimize any adverse effects.

Through a series of presentations and follow-up discussion, the meeting focused on the lessons learnt from the experience of a number of PPPs operating in selected countries in Africa. They included:

- **Botswana**: HIV/AIDS collaborations
- **Ghana**: lymphatic filariasis programme
- **Nigeria**: global PPPs in general
- **Southern African Development Community Countries (SADC)**: Viramune® & Diflucan® Donation Programmes
- **Sudan**: African Programme for Onchocerciasis Control (APOC)
- **Tanzania**: International Trachoma Initiative (ITI) and Sector Wide Approaches (SWAPs)/ Basket Funding
- **Togo**: Onchocerciasis Control Programme (OCP)
- **Various countries in sub-Saharan Africa**: sleeping sickness (African trypanosomiasis).

Although the meeting focused mainly on the perspectives of those implementing existing partnerships in selected countries, a number of broad issues emerged in relation to these kind of partnership activities. Participants recognized that coordinated action is required on many fronts in order to reduce health inequities.

Key priorities identified include the need to:

- Ensure the R&D and introduction of new products for 'neglected' diseases
- Provide support for capacity building and strengthening health service delivery systems
- Ensure that PPPs work through governments and that programmes are designed to strengthen existing health programmes and priorities
- Ensure 'ownership' of the programme among all stakeholders
- Establish key performance indicators in order to streamline the reporting needs of multiple donors
- Plan for the phasing out of the programme and the long-term sustainability of the service provided.

In addition to better access to existing medicines, LMICs need **access to new pharmaceuticals and other health products** to combat diseases such as HIV/AIDS, sleeping sickness, drug-resistant malaria and TB. PPPs involving the manufacturers of pharmaceuticals and other health products have a critical role to play in helping accelerate the R&D and introduction of new products for the treatment of neglected diseases. Moreover, PPPs should play an important role in the push to place neglected diseases high on the international agenda.

Meanwhile, governments of LMICs, multilateral agencies and bilateral aid agencies need to share responsibility for **strengthening health service**

delivery systems. PPPs involved in the supply of pharmaceuticals often fail to take into account that existing health service delivery systems may be both weak and fragile due to a severe shortage of both financial and human resources. To improve the effectiveness of delivery systems, governments need to strengthen capacity in a number of key areas. **Capacity building** should be discussed in all negotiations with partners prior to implementation of a partnership programme and the programme should be designed to improve administrative efficiency, documentation and data management, and build these into existing operational mechanisms. Ministries of health should develop ways of reducing high staff turnover in an effort to retain well-trained professional staff and should have an overall strategy for human resource development. This could be the focus of a capacity building component in each partnership.

Another key issue is the need to recognize the overarching **role of governments**. Global partnerships need to work through governments, respecting national plans as well as district and community needs. Governments must be able to fulfil their role of negotiating, approving and coordinating all public service activities, including those they are not necessarily implementing or involved in. They need to be aware of their overall responsibility, regardless of the number of initiatives and partnerships set up in support of service provision. The creation of partnership programmes to improve access does not relieve governments of their responsibility for creating policy frameworks and coordinating mechanisms. It makes it even more important that they do so.

Governments should establish a common platform within the health system to improve and facilitate the implementation of PPP programmes and these should be designed to **strengthen existing health care services and priorities**. Health sector strategic plans should be strengthened to accommodate such programmes in line with pre-established priorities and coordinate and support their implementation. Harmonizing systems must be in place before programmes are implemented. In the longer-term, programmes should be integrated into national plans, making use of existing systems for delivery, monitoring, reporting and finance.

Participants also highlighted the importance of **ownership of the programme** among all stakeholders. It was recognized that stakeholders should take the time needed to work through key issues, in order to build trust and agree on common target areas. For implementation to be effective, PPPs need to listen to the voice of all stakeholders, including those at community level. Ownership of the programme by all participants — including potential partners — can be fostered by ensuring not only that their voice is heard, but also that their roles are clear. Governments at the local and provincial levels should be encouraged to participate at an early stage in all phases of the programme, together with NGOs and the private sector. All sectors of society should be encouraged to play an active role in the implementation of the programme.

The problem of overlap and duplication in **reporting to donors** was also identified as an important issue. Regular reporting to all partners on the progress of a programme ensures accountability, responsibility, transparency and adherence to agreed programme schedules. However, lack of coordination between donors and the existence of different 'agendas' results in multiple and cumbersome reporting systems and formats which unfairly burden LMICs. Key programme indicators must be identified in order to monitor performance and progress within a country's own framework. Such a framework will also make it easier for bilateral aid agencies to provide support, especially in relation to capacity building. Indicators for assessment should not only measure the different goals and objectives of the programme, but should also evaluate their contribution to improvements in the overall health system.

Finally, the issue of **programme sustainability** was discussed and the need to ensure that programmes are not open-ended. At the earliest opportunity before a programme is implemented, all partners need to know its planned scope — how and when it will be phased out and when it is due to end — in order to make realistic short- and long-term commitments. While pharmaceutical companies should continue donations as a short-term strategy, in the longer term, tax-free importation of differentially priced drugs, vaccines and other health products should be the preferred strategy — an approach that will require additional resources from governments or external aid.

The recommendations included:

- The roles and responsibilities of all partners involved should be specified in the very earliest stages of the programme.
- Realistic goals and commitments should be specified to ensure the programme is likely to have an impact.
- Suppliers of pharmaceuticals should be fully aware of the generally fragile and precarious infrastructure at the national and district levels where the programmes will be implemented.
- Pharmaceutical companies should recognize that capacity strengthening is typically a necessary component if a programme is to be successful.
- Capacity building including both health service delivery systems and human resources should be included in all prior negotiations with partners before implementation.
- Disease control programmes should be integrated within a country's national health system.
- Governments should ensure they have frameworks for disease control programmes and capacity strengthening into which 'partnerships' can integrate.
- To ensure transparency and adherence to national programme objectives, partnerships should be strengthened or integrated within existing government frameworks.
- An operational research component should be integrated into the programme, in order to help modify strategy and improve performance as experience is gained in implementation.
- Regular communication is essential between all players at all levels, in order to hold partners accountable for their actions and improve programme performance.

1. Introduction

The satellite meeting was opened by **Drs Peter Kilima**[1] and **Mwelecele Ntuli Malecela-Lazaro**[2] who welcomed the participants (See Annex 2: List of participants).

Dr Roy Widdus[3] gave a brief overview of the Initiative on Public-Private Partnerships for Health (IPPPH). Its aim is to identify the obstacles involved in improving the health of the poor and to optimize the potential contribution of public-private collaborations in the development and delivery of health products to combat neglected diseases and other health problems in developing countries.[4]

Dr Widdus noted that many people in Sub-Saharan Africa, parts of south-east Asia and Latin America lack access to essential drugs. One of the most damaging ways that poverty undermines health is by limiting access to pharmaceuticals and other health products. This occurs because:

- research-based pharmaceutical companies do not develop products destined for use exclusively in LMICs because they offer a poor potential return on investment
- new products developed for global markets are initially sold at prices only those in wealthy countries can afford — a problem aggravated by the failure of governments in low-income countries to plan for the introduction of a new product
- the weakness of health service infrastructures in LMICs prevents essential drug delivery systems and other health services from reaching the poor, even with inexpensive, off-patent products.

To counter these obstacles, there is a need for more coordinated action on many fronts to reduce health inequities. Governments of LMICs as well as multilateral agencies and bilateral aid agencies must share the responsibility for long-term development of health system infrastructures. Ultimately, LMICs must have access to critically needed newer products for diseases such as HIV/AIDS, sleeping sickness, drug-resistant malaria and TB. PPPs involving manufacturers of pharmaceuticals or other health products have a clear role to play if priority new products for neglected diseases are to become available. Both 'push' (development subsidy), and 'pull' (improved economic return) interventions are needed to ensure new products become available and accessible to people in LMICs. Dr Widdus predicted that PPPs to improve access to selected pharmaceuticals would remain a necessary and expanding feature of actions to improve health in LMICs.

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[1] Dr Peter Kilima, International Trachoma Initiative, Tanzania.

[2] Dr Mwelecele Ntuli Malacela-Lazaro, National Institute for Medical Research, Tanzania.

[3] Dr Roy Widdus, Initiative on Public Private Partnership for Health, Switzerland.

[4] In discussing "Partnerships to Improve Access to Pharmaceuticals" the more comprehensive WHO definition of access is adopted, which includes ensuring appropriate diagnosis and product quality, for example. Under this definition, PPPs should strive not only to ensure access to a health product but also to ensure quality treatment.

2. Lessons from field implementation in selected countries

The meeting focused on the experiences of various PPPs and the lessons learnt in selected countries. The summaries of the various presentations which appear below are intended to reflect the perceptions and views of the speakers and participants at the meeting.

2.1 Challenges for the integration and implementation of targeted initiatives and Sector Wide Approaches

Dr Lola Dare[5] briefly highlighted the need for PPPs, by providing three illustrative examples of partnerships/alliances: (i) the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), a globally coordinated effort to bring the resources of modern science to bear on the control of 10 major tropical diseases; (ii) the Onchocerciasis Control Programme/African Onchocerciasis Control Programme (APOC), a Merck and Co. and WHO collaboration to provide free access to unlimited supplies of Ivermectin® for as long as needed for the treatment of onchocerciasis; and (iii) the Global Alliance for Vaccines and Immunization (GAVI), a global coordination mechanism, which together with its financial arm, the Vaccine Fund, acts to energize the efforts of poorer countries to provide children with access to priority life-saving vaccines.

For each of these partnerships/alliances, Dr Dare gave a short overview of the history and rationale for the programme, the country/ies where it operates, the major players and the factors contributing to its success. PPPs can have a significant impact at the global, regional, national and community level. However, to maximize their effectiveness, partnerships/alliances need a well-delineated structure and agreed roles among partners at the global level. At the regional level, approaches need to address cross-border issues effectively and comprehensively. At the national level, many programmes are still implemented vertically. All too often this involves the duplication of functions and lack of coordination — leading to a wastage of resources and inequity in the distribution of health care services. However, enhanced community ownership at the community level helps increase access to health services.

Dr Dare stressed the ever-growing challenges faced by fragile, overburdened and fragmented health systems in LMICs when multiple partnerships operate simultaneously (e.g. malaria and lymphatic filariasis approaches to bednet promotion and use). Furthermore, the implementation of initiatives such as GAVI with global health goals tends to skew priorities by interacting with already weak health systems. As a result, there is a need for better Sector Wide Approaches (SWAPs) to promote integrated planning, implementation and evaluation of programmes within the health system.

Dr Dare outlined two African-led partnerships: first, the New Partnerships for Africa's Development (NEPAD), a strategy for poverty reduction and sustainable development, which aims to provide affordable drugs for the major high burden diseases, strengthen community involvement, establish secure, integrated and sustainable health systems and improve health management infrastructure; and second, the African Council for Sustainable Health Development (ACOSHED), a Pan African Partnership for health and poverty reduction, which evolved from the World Bank Expert Panel for Better Health in Africa and which focuses on sector reforms, health system development and integration of vertical programmes into national health systems for health and poverty reduction.

[5] Dr Lola Dare, African Council for Sustainable Health Development (ACOSHED), Nigeria.

Discussion

Participants highlighted three key issues: the importance of local priority setting; the lack of clarity on where the responsibility lay for overall strengthening of health systems; and the lack of resources to implement the various programmes.

2.2 SWAPs and Basket Funding: Tanzania experience

Mr Joseph Kelya[6] outlined Tanzania's experience with Sector Wide Appoaches (SWAPs), and Basket Funding, which began in 1998. Mr Kelya briefly explained the importance of SWAP as a long-term partnership between the government and donors, including the UK Department for International Development (DFID), the Danish International Development Agency (DANIDA), Ireland Aid, the governments of Norway and the Netherlands, the Swiss Agency for Development and Cooperation (SDC) and the World Bank. The aim of the partnership is to improve health through collaborative work programmes in a way that marks a complete shift from project performance approaches to sector-wide performance. The characteristics of SWAP include shared goals, negotiated strategies and common management in monitoring performance as well as the formulation of a coherent sectoral policy and common financial, managerial and procedural arrangements. Thus by improving the allocation of national budget and donor flows both within and between sectors, SWAPs are intended to promote the equitable, sustainable and efficient use of all available national and external resources for the benefit of the poor and other excluded and vulnerable groups.

Mr Kelya said health reforms in Tanzania are a continuous process. Although the health sector reform proposal was developed in 1993, it only became operational between 1999-2002. The district level basket funding and disbursement system became operational in 2000. As a result of the openness of the ministry of health and existence of donor partnerships, there has been an increase in constructive dialogue, accountability and transparency. One of the advantages of basket funding is that it ensures a holistic view in supporting various programmes. This avoids the need for individual reporting to each donor — a requirement which entails a large amount of time in report writing for the PPP secretariat and detracts from the implementation of activities. However, one of the drawbacks is that the report for one quarter may not be available when the next allocation is to be decided — resulting in a funding gap and lack of continuity.

Mr Kelya pointed out that the establishment of successful partnerships requires specific building blocks, including: time, a SWAP, and effective coordination and use of donor funds, as well as mutual understanding, agreement and trust among all the partners involved at all levels.

Discussion

Participants challenged the importance of the basket funding, since it is a long-term donor mechanism, which will not include government allocations. According to the agreement between the basket partners and the government, it is stipulated that partners will only put their money into the joint account after ensuring that the government has put in the agreed amount of contribution. However, if the government does not contribute anything, it would not be seen as a true partnership. It was not clear how this was going to increase absorptive capacity since basket funding is not accompanied by adequate capacity building. As part of the reform process, the ministry of health has initiated and completed a country-wide programme to train all Council Health Management Teams in health planning and management. It is envisaged that this training will, among other things, increase absorptive capacity. Furthermore, participants raised the important issue of the problems that the ministry of health would have to face in dealing with two completely different operating systems: the National Health Account and basket funds. While integration of the two systems would be ideal, limited capacity for centralized financial reporting could aggravate a low absorption capacity and delay implementation.

[6] Mr Joseph Kelya, Minitry of Health, Tanzania and Dr Conrad Mbuya, Tanzania Essential Health Interventions Project (TEHIP), Tanzania.

2.3 Onchocerciasis control in Togo

Dr Assimawe Pana[7] looked at the experiences and lessons learned from the implementation of the Onchocerciasis Control Programme (OCP) in the Republic of Togo (one of the 11 countries involved in the OCP in West Africa). About half the population of over 5 million people are at risk of onchocerciasis and the programme covers almost three-quarters of the country geographically. At the outset, the prevalence rate of onchocerciasis in the country was very high (30%-89%). Today it is under 5% in most areas except along the Oti river and its tributaries.

The disease has had a significant socioeconomic impact on the country. Villages struck with onchocerciasis are completely deserted. People blinded by the disease are less productive and ultimately become a burden on their communities. The OCP began its activities in 1974 with a mandate to eliminate onchocerciasis — a major public health problem which impedes socioeconomic development — and to ensure that the disease does not re-emerge at a future date. The OCP is co-sponsored by WHO, the World Bank, UNDP, and the Food and Agriculture Organization (FAO) with WHO as the executing agency and the World Bank in charge of fundraising and management of the OCP Trust Fund. Initially planned as a 20-year programme, the OCP has operated for nearly three decades, successfully meeting its goal of eliminating onchocerciasis. The programme will end in December 2002, and the 11 participating countries will then assume responsibility for carrying out the residual activities.

The main control strategies used in Togo are vector control (aerial and ground larviciding to stop transmission) and procurement and distribution of Ivermectin®. The Ivermectin® distribution was as follows: from 1988-1994 through mobile teams; from 1994-1996 through a community-based treatment system; and from 1996 through a community-directed treatment approach. However, the implementation of this strategy took a long time due to the need to sensitize and train staff (at each level of the health system from the regional level down to village level) prior to their involvement in the programme. Supervision, monitoring and evaluation, as well as data collection had to be carried out at different levels. While supervision was initially carried out mainly by OCP staff, it is now an integral part of other health programmes. One initial problem was the incompleteness of data collection due to a lack of motivation among volunteers (community distributors and nurses). This was resolved by providing some financial incentives to the volunteers, through the "Initiative of Bamako Strategy" funds.

Dr Pana said onchocerciasis is no longer a major health problem in the Republic of Togo. This is largely due to the OCP's success in involving different actors, particularly health workers at the district and community level. However, many challenges remain, including the need to ensure sustainable financing of activities when the programme ends in December 2002. It is essential to maintain and improve the epidemiological and entomological results, improve community-directed treatment coverage, data collection and analysis systems, as well as increase the motivation of the community distributors. While there is a need to identify new donors, it is also essential to integrate the OCP with other activities and make it a key priority for the ministry of health.

[7] Dr Assimawe Pana, World Health Organization/ONCHO (OCP), Burkina Faso.

2.4 HIV/AIDS collaboration: from global concepts to field implementation

Dr Banu Khan[8] gave a brief overview of the HIV/AIDS situation in Botswana and of the different kinds of partnerships that have emerged in response to the epidemic.

Since independence in 1966, Botswana has maintained one of the world's highest growth rates. Through fiscal discipline and sound management, Botswana has transformed itself from one of the poorest countries in the world to a middle-income country with a per capita GDP of US$7,800 in 2001. Diamond mining has fuelled much of the expansion and currently accounts for more than one-third of GDP and for four-fifths of export earnings. On the downside, the government must deal with high rates of unemployment and poverty. While the official unemployment rate is 21%, unofficial estimates place it closer to 40%. HIV/AIDS infection rates are the highest

[8] Dr Banu Khan, National AIDS Coordinating Agency (NACA), Botswana.

in the world and threaten Botswana's impressive economic gains. Out of a population of under 1,600,000, an estimated 330,000 people are living with the disease, including almost 40% of the adult population.

Botswana's cultural values of openness and caring underpin the country's democratic stability and economic growth as well as the present approaches to HIV prevention and AIDS care. In response to the pandemic, the government set up the National AIDS Coordinating Agency (NACA). The agency is housed in the Office of the President, who is very supportive of its work and chairs meetings together with representatives of the ministry of health.

NACA's mandate is to expand the multisectoral response to HIV/AIDS through policy and programme development, monitoring and evaluation of the national response and mobilization of resources. To achieve this, NACA has engaged with strong PPPs at both the international and national level in the implementation of efforts to control the epidemic.

The partnerships at the international level include: the African Comprehensive HIV/AIDS Partnerships (ACHAP), the Botswana-Harvard AIDS Institute Partnership (BHP) and Secure the Future (Bristol Meyers Squibb). At the national level, the partnerships include Debswana, a mining company, and the banking and training sectors.

Although there is strong political commitment to the HIV/AIDS programme, Botswana faces many challenges. The previously well functioning health services are currently breaking down due to the AIDS toll on staff. Furthermore, many nurses have been emigrating to the UK and elsewhere due to the lack of career development at the national level. As a result, Botswana is now trying to recruit medical staff from abroad.

In addition, the government's capacity to control the response is being stretched to the limits by the complex and varying requirements of partner agencies and other supporters in formulating project proposals. During tough but productive negotiations with pharmaceutical manufacturers, for example, an offer of aid was turned down because agreement could not be reached on the conditions.

In order to overcome the challenges of orchestrating the various partnerships, NACA recognizes the need to create a working environment that promotes clear, transparent coordination among the different players. All partners should be involved in the very early stages of planning, each one bringing its own comparative advantages, skills and values. NACA also recognizes the need to create capacities and mechanisms for accessing partner's funding.

Discussion

While some participants argued that governments and the international community should do everything possible to pay for antiretroviral (ARV) treatment for all who need it, others argued that such treatments are primarily a 'private good' and should not be publicly funded. Views on this issue vary widely, highlighting the need to make a policy decision on the use of ARVs in developing countries, where the needs and resource constraints are greatest.

2.5 Lymphatic filariasis control in Ghana: issues for working in partnership for health

Dr Nana Kwadwo Biritwum[9] outlined Ghana's programme to eliminate lymphatic filariasis (LF), which has adopted a multi-sectoral approach. The programme, which has united a broad coalition of partners including politicians, donors and implementers, was planned within the context of other ongoing health programmes and designed to help strengthen local health services.

The programme is involved in a wide range of activities including research, human resource development, networking and institution and infrastructure building. It is managed by an executive secretariat and a taskforce of major stakeholders, including scientists, policy-makers, politicians, the press and other international and local partners. Together they oversee the strategic planning, coordination, technical support and resource management of the programme.

The major international partners include DFID, WHO, Merck and Co., GlaxoSmithKline (GSK), the Bill and Melinda Gates Foundation, and the Liverpool Lymphatic Filariasis Support Centre. Local partners include the Noguchi Memorial Institute for Medical Research, World Vision

[9] Dr Nana Kwadwo Biritwun, Filariasis Elimination Programme, Ghana.

International (Ghana), and a coalition of NGOs involved in health-related activities. These partners provide financial, technical, capacity building and logistics support and help with the provision of vehicles, equipment and supplies of Ivermectin® and Albendazole® for distribution.

The role of the scientists includes: carrying out surveys and mapping out the spread of the disease; conducting drug trials to establish the efficacy of the different treatment regimens; and operational research on Ivermectin® and Albendazole® distribution. The policy-makers' role is to assess the extent of the problem and find ways of integrating LF into existing health delivery systems and interventions, while the press provides assistance in communication and awareness building about the consequences of the disease.

Dr Biritwum illustrated how Ghana was able to take the lead in defining its own programme objectives through the involvement of relevant stakeholders with expertise in disease control and the design and implementation of programmes. As a result, external capacity was mobilized in response to research needs.

All too often, vertical programmes have to settle difficult issues including: the need to establish ownership and ensure sustainability; the need for capacity building and coordination at country level; and problems involving the duplication of functions. Meanwhile, lack of coordination between donors and their different agendas also makes it difficult to report on more than one programme at a time — resulting in cumbersome reporting systems and formats. The solution is to have a uniform system of reporting and to ensure that governments play a key role by working together with international and national partners, which in turn need to respect national plans and district and community needs. In addition, there is a critical need to ensure better collaboration in key areas such as transparency and sensitivity to local customs and traditions.

Discussion

Some participants questioned why the onchocerciasis programme was not integrated with the LF programme, since both share common objectives, similar approaches and make use of the same drug, Ivermectin®. Some argued that separating related programmes would not be cost effective in the long-run. On the contrary, it would overburden already weak and fragile communities with other parallel vertical programmes.

2.6 Donation programmes for HIV/AIDS-related drugs

Dr Sibongile Pefile[10] outlined the findings of an IPPPH-funded survey which she had carried out on the lessons learnt from the early stages of two drug donation programmes designed to improve access to HIV/AIDS-related drugs (Diflucan® andViramune®).

In December 2000, Pfizer Inc. announced its partnership with the South African government to donate Diflucan® (flucaoazole) for the treatment of HIV-related opportunistic infections (cryptococcal meningitis and oesophageal candidiasis). In June 2001, the programme was extended to include the unlimited donation of this antifungal medicine to be given free of charge to HIV/AIDS patients in the 48 Least Developed Countries. The partnership, which operates in cooperation with the UN and WHO, works closely with NGOs. The programme is operational in Botswana, Haiti, Ghana, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania and Zambia. In addition to treatment, the programme also involves health education for both patients and healthcare providers, appropriate dispensing of medicines, and ongoing monitoring and support from partner governments.

In July 2002, Boehringer Ingelheim Pharmaceuticals donated the antiretroviral drug nevirapine (Viramune®), which prevents mother-to-child transmission (MTCT) of HIV-1. The company committed to providing the drug free of charge to developing countries for five years for use in prevention of MTCT. Countries whose governments adhere to WHO drug donation guidelines can formally request to receive the drug. The distribution and administration of Viramune® at the country level is carried out through interested governments, NGOs and UN organizations. The implementation, management and monitoring of the drug donation programme has been contracted to an independent third party, Axios

[10] Dr Sibongile Pefile, The Center for Management of Intellectual Property in Health R&D (MIHR), UK.

International. The donation is part of the Accelerating Access Initiative, a partnership designed to increase access to HIV/AIDS drugs in developing countries. The initiative includes Boehringer Ingelheim, Bristol-Meyers Squibb, F. Hoffman-La Roche, Glaxo-Wellcome, Merck and Co.,UN agencies, the World Bank and developing country governments.

Dr Pefile's survey revealed that the 'added value' of donation programmes lies in strengthening and improving health care delivery services, building capacity and involving a wide chain of partners with well-defined roles. However, drugs for opportunistic infections often result in requests from recipients for additional support to improve their health care delivery systems.

Although it was difficult to measure the challenges involved in accommodating the different perspectives of the pharmaceutical donors, national authorities, public health providers and NGOs, one of the major lessons learnt from these two donation programmes was the need for early negotiations in order to ensure appropriate representation of the various stakeholders. The need for local leadership and motivation is also extremely important, in order to support initiatives and implement them on the ground. Another finding was that without good training and capacity development it would be difficult to implement comprehensive and integrated approaches at all levels of the health care system. For partnerships to succeed, there is a need to: develop excellent working relations; engage other sectors; develop a creative outlook; and establish a common goal. Dr Pefile also underlined the importance of policy development, an effective management structure, good infrastructure, adequate resources and efficient operating systems for a successful drug donation programme.

Discussion

While participants generally agreed that drug donations can be seen as genuine goodwill gestures by a well-intentioned pharmaceutical industry, a number of concerns were voiced about the long-term impact of drug donation programmes. There was a need to consider the implications of drug donations for national policy, a country's capacity to fund these health commodities after the end of a donation and the possible impact on commodity values in poorly resourced public sectors.

2.7 African Onchocerciasis Control Programme: Sudan experience

Dr Suad Sulaiman[11] outlined Sudan's experience as a member of the African Programme for Onchocerciasis Control (APOC). Sudan joined APOC late, mainly because of the chronic instability and civil unrest in the country. Since 1983, war and a related famine have killed over 2 million people and left over 4 million people internally displaced (out of a total population of over 37 million).

The onchocerciasis control programme involves vector control activities and distribution of the drug Ivermectin® through a community-directed distribution and treatment system. Treatment sites are spread across the south-west of the country and in a few locations in the north. The number of treatments has increased from over 19,000 in 1997 to over one million in 2001. The organization has a hierarchical structure extending from the national coordinator to the community drug distributors (CDDs).

Dr Sulaiman outlined some of the challenges involved in sustaining the programme in a country affected by civil unrest such as improving the existing primary health care system with a view to integrating onchocerciasis control activities within it. Sudan is currently trying to integrate APOC within overall health services and other programmes, in particular with the trachoma and lymphatic filariasis control programmes.

In addition, the programme faced an uphill struggle in encouraging the government and NGOs to support and supplement assistance and in introducing health education as part of the school curriculum in affected areas. Another important challenge was the need to retain the community drug distributors involved in the programme in the face of competition from other UN agencies and NGOs, which often remunerate their working staff. The solution found was to restore community volunteer support in a few areas in the south by using the World Food Programme's Food For Work programme as an incentive.

[11] Dr Suad Sulaiman, Tropical Medicine Research Institute, Sudan.

Discussion

Participants acknowledged the challenges involved in running a disease control programme in conflict situations. Since the onchocerciasis control programme is the only health programme able to reach people in some remote areas — providing support to primary health care services and some basic health education in schools — participants stressed the need for more rigorous programme surveillance and supervision, especially in conflict zones where communities have no other access to health care.

APOC funding will end in 2003 and the activities will be managed by the ministry of health and other NGOs in order to ensure the sustainability of the national control programme for at least five years.

2.8 International Trachoma Initiative: Tanzanian experience

Dr Peter Kilima[12] provided a comprehensive overview of the International Trachoma Initiative (ITI) in Tanzania. He pointed out that trachoma is a disease of major public health importance. Worldwide, 6 million people have been blinded by trachoma, 150 million are in need of immediate treatment to prevent them going blind and 540 million are at risk of infection. In Tanzania, out of a population of over 34,500,000 people, 45,000 have been blinded by trachoma, 2 million are in urgent need of treatment and 12 million are at risk of infection.

Established in 1998 by the Edna McConnell Clark Foundation and Pfizer Inc., the ITI seeks to eliminate blinding trachoma by the year 2020, in line with a 1998 resolution of the World Health Assembly (WHA 51.11).

The initiative was launched in Tanzania in August 1999 following preliminary surveys to establish baseline data. The programme operates through a PPP involving Helen Keller International, Sight Savers International, Christofel Blinden Mission, local NGOs and the endemic districts and communities themselves. Partners meet four times a year to review progress. Each has a defined role and brings their own expertise to the programme. Elsewhere in Africa, ITI programmes are also under way in Ghana, Mali, Morocco and Sudan. Programmes are also being developed in Niger, Egypt and Ethiopia.

The main strategy adopted by ITI is known as SAFE, which stands for Surgery, Antibiotics, Face washing and Environmental improvement. The SAFE strategy was translated in Kiswahili to SAFI, which means 'clean' and 'nice'. The country programme in Tanzania has been successful in building up community awareness and understanding of the disease, which increased to 70%. Progress in meeting disease reduction targets has been dramatic. Within six months, the incidence of severe trachoma had been halved.

The initial problems faced by the ITI in Tanzania were: the vertical nature of the programme in the context of a proliferation of country programmes; lack of adequate equipment in most districts; shortage of key skills (e.g. for surgery at the community level); inadequate resources for outreach activities; and lack of standardization in reporting. These problems have now been solved. Trachoma control activities are now part and parcel of the district comprehensive health plans and the relevant equipment and resources have been made available. The current strategy involves targeted treatment where prevalence is above 10% but below 20%, and mass treatment where prevalence is 20% or more.

The lessons learnt included the need to ensure joint planning and regular meetings to strengthen partnerships; build appropriate capacity at the community and district levels; and use scarce resources cost effectively.

Discussion

One participant questioned whether ITI was relying too heavily on a treatment approach for a problem which, in theory, might be controlled by building awareness at the community level of the need for face washing. However it was also noted that the SAFE approach involved a balanced set of interventions. It was pointed out that for most diseases, a treatment strategy was essential for humanitarian reasons and because an exclusive focus on prevention would be seen as a failure to serve the community. But participants agreed that there is a need to continue building local partnerships for education to prevent trachoma via hygiene, in parallel with water supply development, while continuing to provide treatment for those who already have the disease.

[12] Dr Peter Kilima, International Trachoma Initiative, Tanzania.

2.9 WHO Programme to Eliminate Trypanosomiasis

Dr Jean Jannin[13] outlined the WHO Programme to Eliminate Sleeping Sickness (African trypanosomiasis). He said sleeping sickness is one of the most neglected diseases and very little is invested in the R&D of new drugs and diagnostic tools. The disease occurs mainly among the poor in rural areas in sub-Saharan Africa. Diagnosis and treament of those affected is extremely difficult due to the lack of adequate health facilities.

The strategy developed to combat neglected diseases such as sleeping sickness and help reduce poverty involves efforts to increase access to health services; to make available 'toolboxes' for diagnosis and treatment of the disease; and to develop ways of reaching populations with no access to health services. Another key component of the strategy is the use of advocacy and media campaigns to raise awareness of the disease and of the elimination efforts. Launched in May 2001, the WHO Programme to Eliminate Sleeping Sickness is a public-private partnership with a range of partners including Aventis, Bristol-Myers Squibb, Bayer AG, the Bill & Melinda Gates Foundation, Médecins Sans Frontières, NGOs and the governments of Belgium and France. Through this partnership, specific drugs are now available free of charge for the populations affected. The multi-pronged approach involves efforts to negotiate and ensure an adequate supply of safe and effective drugs; carry out disease surveillance; provide access to treatment; increase research activities; and raise sufficient funds to extend the elimination programme to all endemic countries. At the same time, the programme is trying to improve all organizational aspects of coordination and networking involving national control programmes, NGOs, research institutes, bilateral cooperation and the private sector — a combined approach that is helping restore links between populations living in endemic areas and the health system.

In order to create strong links between all actors involved, the programme has established coordination mechanisms and cohesive sets of activities throughout Africa. In addition, networks have been established to address cross-cutting issues such as: the need to establish a system for monitoring drug resistance; - coordination of clinical trials; vector control: and implementation of field research at national level.

One of the main aims of the programme is to provide support to countries in order to: improve national capacities; develop field activities; and improve health facilities to ensure that all those affected are diagnosed and treated. Efforts are already under way to strengthen national programmes and provide equipment in order to train people for screening exposed populations. The goal is to convince ministries of health to appoint enough people in related services — not only high-level researchers, but also doctors and health workers to work in the field — and to provide incentives for health workers to ensure the sustainability of national control programmes. In central Africa, where the disease is now occurring at a low level, the programme is developing an inter-country approach which involves the sharing of technical expertise between several countries.

Dr Jannin outlined a number of programme constraints including: a shortage of resources (including inadequate transport facilities); a lack of trained medical staff and equipment; and inadequate access to safe drugs and effective treatment. These problems are often due to a lack of political commitment, weak health systems, political instability and insufficient investment in the R&D of new drugs and diagnostic tools.

[13] Dr Jean Jannin, Surveillance and Response, Department of Communicable Disease, World Health Organization, Switzerland.

3. Working group discussions

Participants were invited to join a working group on PPP issues focusing on one of the following topics:

Group A: Issues for governments and /or multilateral agencies

Group B: Issues for implementers

Group C: Issues for suppliers of pharmaceuticals.

The sessions were followed by a plenary discussion to identify cross-cutting themes. In order to actively engage all participants in the discussion, PPP was defined to encompass any formal or informal relationship which helps engage the diverse skills and resources of varied public/ governmental agencies and private sector organizations in order to overcome hitherto intractable problems in global public health.

Some examples of the various mix of PPPs include public sector programmes with private sector participation, operating under the auspices of intergovernmental agencies, and not-for-profit public-private partnerships operating under the national laws of various countries.

Among the issues raised during the plenary were:

- The role of the government
- Ownership of the programmes
- Implementation through coordination and integration across programmes
- Integration within national priorities
- Capacity building and health system strengthening
- Reporting and feedback
- Sustainability.

Role of governments

Throughout the three group presentations it became clear that there is general agreement that governments must be able to fulfil their role of coordinating, negotiating and approving all public service activities, including those they are not necessarily implementing or participating in. Governments can negotiate what they describe as contributions to collaborations, in addition to what is initially proposed. Furthermore, global partnerships have to work through governments, respecting national plans as well as district and community needs.

One of the messages that emerged from the discussion was that governments need to be aware of their overall responsibility, despite the proliferation of global initiatives and partnerships established to support service provision. The creation of partnership programmes to improve access does not relieve governments of their responsibility for creating policy frameworks and coordination mechanisms. On the contrary, it makes it more important that they do so.

While some countries with very weak internal systems may need to accept more support on an emergency basis without much local priority setting, such acceptance is still a government responsibility. Where governments need to be supported in this role, regional fora and international agencies have a particular role to play.

Ownership of the programmes

The question of ownership was a key issue for participants. Global partnerships need to cooperate with governments and understand and respect their priorities at national, district and community level. It was recognized that the various stakeholders should take the time to listen to one another and work through important issues, in order to build trust and agree on common target areas.

Implementation through coordination and across programmes

Health programmes are designed to achieve specific outcomes by performing specific inter-

ventions and/or providing particular services. The ministry of health is responsible for identifying the gaps preventing completion of the programme and for negotiating with all partners to fill these gaps as part of the programme implementation. The ministry should drive the agenda of the control programme and appoint a focal person to ensure its effective implementation. It should also set clear-cut roles and responsibilities for all partners, assess the available resources and devise a sustainable strategy to address and control these programmes, establishing mechanisms for coordinating partners through regular consultative meetings. Such meetings are extremely useful in holding partners accountable and improving the overall performance of the programme. During the evaluation phase, implementers will be able to make informed judgments about improving the programme, extending it to other sites, cutting back or abolishing it so that resources can be allocated elsewhere. Throughout this process, the district is the ultimate implementation area. Community members or their local representatives must be directly involved. Moreover, their views and interests need to be better represented in PPPs as a whole.

Integration within national priorities

For a PPP to be successful, a common platform should be established within the health system to improve and facilitate implementation and new programmes should be established to strengthen existing programmes. Countries should develop or strengthen health sector strategic plans to facilitate programme implementation within an established framework. All partners involved should recognize the importance of such strategic plans and support their development. Coordination among all partners is vital and should be improved. In the long-term, programmes should be integrated into national plans, making use of existing systems for delivery, monitoring, reporting and finance.

Capacity building and health system strengthening

Health infrastructure and services need to be strengthened if they are to respond adequately to the ever-increasing health epidemics afflicting LMICs. Structures, organizations, skills and resources in the health sector are rarely adequate for service delivery and even less for coordinated action with other stakeholders.

Participants agreed that capacity building was a key requirement (often neglected in some vertical programmes) for the development of sustainable skills, structures and resources needed to maintain and build on health gains. Each partner should develop an integrated set of strategies across a number of key areas to ensure effective capacity building.

Since it is often very difficult to retain well-trained professional staff, the ministry of health should identify the reasons for this and negotiate with partners to ensure that human resource development is an integral part of the programme implementation strategy. Ways of motivating and/or rewarding community level implementers should be considered on a case-by-case basis, possibly leading towards career development. In some cases, staff turn over is so high that training needs to be constantly repeated — thereby slowing down the programme. Capacity building should be included in all prior negotiations with partners before programme implementation gets under way. It should be designed to improve administrative efficiency, documentation and data management and build these into existing operating mechanisms.

International and private partners should recognize that they have a critical role to play in ensuring that overall health system capacity is strengthened — over and above the needs of drug donation programmes. It is also important that suppliers of pharmaceuticals are fully aware of the conditions and available capacities in the countries where a programme will be implemented. For this reason, frequent visits by senior management to the field can help sensitize them to the needs. Pharmaceutical companies should consider funding capacity building, or at least help mobilize resources for this.

While recognizing that some company information is commercially sensitive, participants agreed that companies should be as open and transparent as possible on the criteria used in making decisions about donations and eligibility for discounted pricing as well as other aspects of the programme.

Reporting and feedback

Programme indicators must be worked out in order to monitor key features such as performance and progress. This will also make it easier for bilateral aid agencies to provide support,

especially for capacity building. Regular evaluation should be used not only to assess the different goals and objectives of the programme, but also to ensure improvements in health systems.

Regular reporting and feedback ensures accountability, responsibility and transparency as well as adherence to agreed programme schedules. While outcome and impact are the desired endpoints, targets are often not met due to factors outside the control of the programme. It is therefore important to include selected indicators that can show whether the programme has completed interventions as stated in the plans. If the choice of the intervention was a sound one, it would at least have prevented an even worse situation: a very efficient programme may be in danger of closure even though it has actually 'delivered' as expected.

Where several programmes are implemented or coordinated though the same structure and staff, reporting becomes burdensome — especially if there are neither the staff nor the time to fill out the various progress report forms required for each partner. In the end, more time may be spent filling out reports than on implementing programmes. This leads to poor data quality, incomplete results and inadequate documentation — possibly even endangering the future of a programme.

Programmes must not overburden already weak government systems, including health management information systems that are overburdened with routine health service data collection, recording and transfer. Instead, partners should agree on a limited and manageable set of shared data and indicators which fit into the existing system. More detailed data needed by individual programmes should be collected in other ways, such as through special surveys or other targeted approaches conducted by project staff. While detailed programme-specific data and indicators still need to be shared, this should be done at an appropriate organizational level (district, regional or national) and be integrated into joint reports.

Sustainability

In order to make realistic short- and long-term commitments, partners need to know at the earliest possible date the planned scope of the programme to be implemented, how and when it will phased out and its overall duration. Programme maintenance and sustainability are indispensable elements, which ensure that it can be delivered through a network of agencies in addition to or instead of the agency which initiated the programme. Therefore, it is advisable to incorporate sustainability measures from the outset. Operational research on drug delivery systems, for example, should be encouraged in order to help ensure sustainability. Making use of existing delivery systems in a country is one way of sustaining the programme. While the pharmaceutical companies should continue donations as a short-term strategy, tax-free importation of drugs, vaccines and other health products should be the medium- to long-term approach.

4. Conclusions

Both the individual presentations and group discussions highlighted the fact that in many low-income countries, governments alone do not have the capacity or resources to deliver adequate health services. In order to improve the overall health status of poor populations and help further a country's socioeconomic development, there is a need for community participation and for coordinated action involving all interested parties. A multi-sectoral collaborative approach is one of the most sustainable ways in which to improve the health status of the most vulnerable populations in LMICs. In low-income countries, high priority should be given to the development of human resources in all sectors to support related activities. National governments, in cooperation with local authorities, NGOs and the private sector, should prepare periodic reports on the progress of the targeted access programmes with clear indications of how vulnerable groups are faring.

Within the context of national plans, governments should formulate, adopt and implement programmes and strategies to achieve their established goals, taking into account specific problems and priorities. Countries with very weak internal systems may need more urgent support. Governments at the local and provincial levels should be encouraged to participate at an early stage in all phases of the process, together with NGOs and the private sector. Governments should establish appropriate national mechanisms to prioritize, develop, implement and monitor policies to improve health status within designated time-frames, based on national and local needs and provide appropriate funds. All sectors of society should be encouraged to play an active role in implementing the programme. NGOs, private institutions, and the pharmaceutical industry, in close association with the government and technical service sectors, should be mobilized to help targeted population groups improve their health status. Programmes should be adequately resourced in order to ensure their sustainability.

A key message that emerged from this meeting is that there are many barriers and constraints to implementing health care programmes in developing countries. Most of these occur because heath services are weak and fragile due to financial and human capacity constraints. Therefore, offers of targeted support from developed countries via 'access' PPPs must go hand in hand with the development and implementation of national health care programmes. PPPs should play an important role in the push to place neglected diseases high on the international health agenda.

In order to implement PPPs, it is imperative to sensitize leaders at the global, national, business or community level, to the needs of the poorest populations. Although efforts to reach consensus among all partners may take a long time, it is critical for success. Moreover, partnerships that seem to work best are those in which responsibilities and roles have been clearly defined at an early stage, and where implementation procedures are under a policy framework set by the government.

5. Recommendations

- The roles and responsibilities of all partners involved should be specified in the very earliest stages of the programme.
- Realistic goals and commitments should be specified to ensure the programme is likely to have an impact.
- Suppliers of pharmaceuticals should be fully aware of the generally fragile and precarious infrastructure at the national and district levels where the programmes will be implemented.
- Pharmaceutical companies should recognize that capacity strengthening is typically a necessary component if a programme is to be successful.
- Capacity building including both health service delivery systems and human resources should be included in all prior negotiations with partners before implementation.
- Disease control programmes should be integrated within a country's national health system.
- Governments should ensure they have frameworks for disease control programmes and capacity strengthening into which 'partnerships' can integrate.
- To ensure transparency and adherence to national programme objectives, partnerships should be strengthened or integrated within existing government frameworks.
- An operational research component should be integrated into the programme, in order to help modify strategy and improve performance as experience is gained in implementation.
- Regular communication is essential between all players at all levels, in order to hold partners accountable for their actions and improve programme performance.

Annex 1: Agenda

Sunday, 10 November 2002 (Day One)

1.30 p.m. – 1.45 p.m.	Welcome and introductions by co-chairs: • **Dr Peter Kilima**, International Trachoma Initiative (Tanzania) • **Dr Mwelecele Ntuli Malecela-Lazaro**, National Institute for Medical Research (Tanzania) Format for workshop • **Dr Roy Widdus**, Initiative on Public-Private Partnerships for Health (IPPPH) (Switzerland)
1.45 p.m. – 2.15 p.m.	Challenges for the integration and implementation of targeted health initiatives and Sector Wide Approaches • **Dr Lola Dare**, African Council for Sustainable Health Development (ACOSHED), (Nigeria) *(20 minutes; 10 minutes for questions)*
2.15 p.m. – 2.30 p.m.	SWAPs and Basket Funding: Tanzania experience • **Mr Joseph Kelya,** SWAPs/Basket Funding, Sector Reform Programme, Ministry of Health (Tanzania) *(10 minutes; 5 minutes for questions)*
2.30 p.m. – 2.45 p.m.	Experiences of SWAPs and health basket funds in two rural districts in Tanzania • **Dr Conrad Mbuya**, Tanzania Essential Health Intervention Project (Tanzania) *(10 minutes; 5 minutes for questions)*
2.45 p.m. – 3.15 p.m.Ø	Lessons learnt from the implementation of the Onchocerciasis Control Programme in Togo • **Dr Assimawe Pana**, Ministry of Health (Togo) (currently seconded to the Onchocerciasis Control Programme in Ouagadougou (Burkina Faso) *(20 minutes; 10 minutes for questions)*
3.15 p.m. – 3.45 p.m.	***Break***
3.45 p.m. – 4.15 p.m.	HIV/AIDS collaboration: from global concepts to field implementation • **Dr Banu Khan,** Ministry of Health (Botswana) *(20 minutes; 10 minutes for questions)*
4.15 p.m. – 4.45 p.m.	Lymphatic filariasis control in Ghana: issues of working in partnership for health • **Dr Nana Kwadwo Biritwum**, Ghana Filariasis Elimination Programme, Ghana Health Service (Ghana) *(20 minutes; 10 minutes for questions)*
4.45 p.m. – 5.15 p.m.	HIV/AIDS-related drugs: The donation programmes for Diflucan® and Viramune® • **Dr Sibongile Pefile** (South Africa) *(20 minutes; 10 minutes for questions)*

End of Day One

Monday, 11 November 2002 (Day Two)

9.00 a.m. – 10.30 a.m. The African Onchocerciasis Control Programme (APOC) in Sudan
- **Prof. Suad Sulaiman**, Tropical Medicine Research Institute (Sudan)

The International Trachoma Institute: The Tanzania experience
- **Dr Peter Kilima,** International Trachoma Institute (Tanzania)

Trypanosomiasis control: Prerequisites for successful implementation
- **Dr Jean Jannin**, Department of Communicable Diseases, World Health Organization (Switzerland)

(20 minutes each and 10 minutes for questions)

10.30 – 10.45 a.m. ***Break***

10.45 a.m. – 12.30 p.m. Discussion groups:

A. Issues for governments and/or multilateral agencies action
Chair: **Dr Winnie Mpanju-Shumbusho,** HIV/AIDS Department, World Health Organization (Switzerland)

Rapporteur: **Dr Danny Haddad**, Helen Keller International (Tanzania)

B. Issues for implementers
Chair: **Dr Nana-Kwadoo Biritwum**, Ghana Filariasis Elimination Programme. Ghana Health Service (Ghana)

Rapporteur: **Dr Josephine Nambooze**, World Health Organization (Uganda)

C. Issues for suppliers of pharmaceuticals
Chair: **Ms Mai Harper**, Health Systems and Maternal Health, Department for International Development (DFID), (United Kingdom)

Rapporteur: **Ms Liza Kimbo**, Sustainable Healthcare Enterprise Foundation (Kenya)

12.30 p.m. – 2.00 p.m. ***Lunch***

2.00 p.m. – 3.00 p.m. Discussion groups *(continued)*
(As above)

3.00 p.m. – 3.15 p.m. ***Break***

3.15 p.m. – 4.15 p.m Reports from discussion groups A, B, and C.
(10 minutes each and 10 minutes for questions and discussions)

4.15 p.m. – 5.30 p.m. General discussion

5:30 P.M. - Close of Meeting

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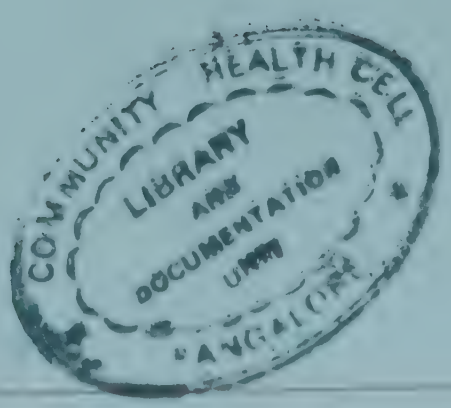

The aim of the Initiative on Public-Private Partnerships for Health is to increase the effectiveness of public-private collaboration, particularly by helping those seeking to develop health products, or to improve access to such products needed to fight neglected diseases and other health problems in developing countries.

Created in 2000 in Geneva, Switzerland, the Initiative on Public-Private Partnerships for Health is sponsored by the Bill and Melinda Gates Foundation, the Rockefeller Foundation and the World Bank. It operates under the aegis of the Global Forum for Health Research, an independent international foundation helping to correct the 10/90 gap in health research, from which it also receives support (www.globalforumhealth.org).

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